

PLACE OF BIRTH

1. County of Maricopa

District of _____

Town of Miami

or

City of _____

ARIZONA STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

ORIGINAL CERTIFICATE OF BIRTH

State Index No. 128County Registrar No. 658

Local Registrar No. _____

No. Miami Inspiration Nat'l St. _____ Ward _____

(If birth occurred in a hospital or institution, give its NAME instead of street and number)

2. Full name of child Jay William Graham If child is not yet named, make supplemental report, as directed.3. Sex of Child male To be answered ONLY in event of plural births. 4. Twin, triplet or other _____ 5. No., in order of birth _____ 6. Legitimate? yes 7. Date Dec. 5 1930 Month Day Year

FATHER		MOTHER	
8. Full name	<u>Jay Clegg Graham</u>	14. Full maiden name	<u>Mareon Jackling Adams</u>
9. Residence (Usual place of abode)	<u>Superior Arizona</u>	15. Residence (Usual place of abode)	<u>Superior</u>
If nonresident, give place and state		If nonresident, give place and state	
10. Color or race	<u>White</u>	16. Color or race	<u>White</u>
11. Age at last birthday	<u>35</u> (Years)	17. Age at last birthday	<u>32</u> (Years)
12. Birthplace (city or place)	<u>Texas</u>	18. Birthplace (city or place)	<u>Colorado</u>
(State or country)		(State or country)	
13. Occupation	<u>Mining Contractor</u>	19. Occupation	<u>Housewife</u>
Nature of industry		Nature of industry	

20. Number of children of this mother (Taken as of time of birth of child herein certified and including this child.)	(a) Born alive and now living <u>2</u>	21. Were precautions taken against ophthalmia neonatorum?
	(b) Born alive but now dead <u>0</u>	<u>Yes</u>
	(c) Stillborn <u>0</u>	

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was Born alive at 1:20 A m. on the date above stated.

*When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.

Signature _____

Address _____

(Physician or midwife)

Given name added from supplemental report _____

Month, day, year.

Registrar.

Filed Dec 15 30 19

Filed _____ 19

Local Registrar.

County Registrar.

174-1208-412